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GUY R. MILONE, JR.
OF COUNSEL
GEORGE T. MILLER
1936-2010

November 16, 2016

JONATHAN GUERRERO
2 WHITMORE LANE PH
CORAM, NY 11727

RE: THE NEW YORK AND PRESBYTERIAN HOSPITAL
[redacted]8346

Dear Sir / Madam:

This office represents THE NEW YORK AND PRESBYTERIAN HOSPITAL in connection with your outstanding bill. Please provide us with any insurance or other payment information that may assist us in resolving this matter.

Please indicate if you would like this hospital service to be considered for one of the Hospital's Financial Assistance Programs or Charity Care Programs.

Very truly yours,

Miller & Milone, P.C.
Account Representative:
Antonio Servellon
Ext: 307

Account Information:

Patient:	JONATHAN GUERRERO
Hospital Account:	[redacted]9284
Account:	[redacted]8346
Date of Service:	03/25/2016
Balance Due:	$200.00

THIS IS AN ATTEMPT TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE. THIS CORRESPONDENCE IS FROM A DEBT COLLECTOR.
Unless you notify this office within 30 days after receiving this notice that you dispute the validity of this debt or any portion thereof, this office will assume this debt is valid. If you notify this office in writing within 30 days from receiving this notice that the debt, or any portion thereof, is disputed, we will obtain verification of the debt or a copy of a judgment and we will mail a copy of such verification or judgment to you. If you request this office in writing within 30 days after receiving this notice, this office will provide you with the name and address of the original creditor, if different from the current creditor.

NETWORK RECOVERY SERVICES, INC.
P.O. Box 28898
New York, NY 10087-8898

ACCOUNT IDENTIFICATION

Client Name:	NewYork-Presbyterian/Columbia University Medical Center
Patient Name:	JONATHAN GUERRERO
Account #:	[redacted]8990
Hospital #:	[redacted]9768
Date(s) Of Service:	06/27/16
Balance Due:	$30.00

DEMAND FOR PAYMENT

The above referenced client has assigned your past due account to our agency for collection. Your account is listed as delinquent with a balance due in the amount of $30.00. It is important that you make payment in full.
If your account has already been paid, please provide us with proof of payment. Please send a copy of your cancelled check, money order receipt, payment receipt or copy of the explanation of benefits provided by your insurance carrier.

If your account has not been paid you may send your check or money order or pay by using one of the Credit Cards indicated below. If you have (had) valid insurance for the dates of service that you believe covers these charges, please complete the insurance information section on the reverse side of the return portion of this notice. Please detach the bottom portion of this notice and forward it with your payment or correspondence in the envelope provided.

Although we have requested that you make payment, or provide proof of payment if payment has been made, you still have a right to dispute this debt, either orally or in writing, and to obtain more information about the debt. **YOUR RIGHTS ARE DESCRIBED ON THE REVERSE SIDE OF THIS NOTICE.**

IF YOU ARE EXPERIENCING FINANCIAL HARDSHIP AND ARE UNABLE TO PAY THIS BILL, CHARITY CARE MAY BE AVAILABLE IF YOU QUALIFY. PLEASE CONTACT US TO OBTAIN INFORMATION ABOUT CHARITY CARE AND HOW TO APPLY FOR IT.

Sincerely,

JULIETTE MCGHEE
Account Representative
516-240-6602

THIS IS A COMMUNICATION FROM A DEBT COLLECTOR. THIS IS AN ATTEMPT TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

IONNREC01500

Detach and Return with Payment or Correspondence

ONNREC01
PO Box 1022
Wixom MI 48393-1022
ADDRESS SERVICE REQUESTED

Client Name:	NewYork-Presbyterian/Columbia University Medical Center
Patient Name:	JONATHAN GUERRERO
Account #:	[redacted]8990
Hospital #:	[redacted]9768
Date(s) Of Service:	06/27/16
Balance Due:	$30.00

November 15, 2016

500 272845180

JONATHAN GUERRERO
2 Whitmore Ln PH
Coram NY 11727-1028

MAIL ALL CORRESPONDENCE TO:
NETWORK RECOVERY SERVICES INC
P.O. Box 28898
New York, NY 10087-8898

IF PAYING BY CREDIT CARD, FILL OUT BELOW	
CARD NUMBER	
CARD HOLDER NAME	EXP. DATE
SIGNATURE	AMOUNT AUTHORIZED

If you do not dispute the validity of the debt, or any portion thereof, either orally or in writing, within thirty days after you receive this notice we will assume this to be a valid debt owed by you.

If you notify us in writing within thirty days after you receive this notice that the debt, or any portion thereof, is disputed, we will obtain verification of this debt or a copy of a judgment and mail a copy of such verification or judgment to you.

In the event the name and address of the current creditor is different from the original creditor, and you, within thirty days after you receive this notice, request in writing the name and address of the original creditor, we will supply this information to you.

INSURANCE INFORMATION

PATIENT'S NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER
BLUE CROSS/BLUE SHIELD ID NO.		SUFFIX	YOUR TELEPHONE NUMBER
INSURANCE COMPANY NAME & ADDRESS (INCLUDE SIGNED CLAIM FORM)			
POLICY NUMBER	POLICYHOLDER'S NAME	RELATION TO PATIENT	POLICYHOLDER'S DATE OF BIRTH
NAME, ADDRESS AND TELEPHONE NUMBER OF INSURED'S EMPLOYER			
MEDICAID ID NUMBER	MEDICARE ID NUMBER	SUFFIX	